HEALTH AND SENIOR SERVICES
OFFICE OF MANAGED CARE

Managed Care Plans Compensation for Health Care Facilities When Other Health Care Providers Are Non-participating

Proposed New Rules: N.J.A.C. 8:38C-4

Authorized By: _____
Clifton R. Lacy, M.D., Commissioner,
Department of Health and Senior Services.

Authority: N.J.S.A. 26:2S-6.1.

Calendar Reference: See Summary below for explanation of exception to calendar requirements.

Proposal Number: PRN 2004-130

Submit comments by June 4, 2004 to:

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The agency proposal follows:

Summary

The proposed new rules set forth at N.J.A.C. 8:38C-4 are intended to implement section 2 of P. L. 2001, c. 367 (as codified, N.J.S.A. 26:2S-6.1), enacted January 8, 2002 (hereafter, "the Act"). The Act applies to coverage that includes both in-network and out-of-network benefits, such as point-of-service products, and products often referred to as preferred provider plans. These types of products provide incentives for covered persons to use health care providers that participate in the carrier's network,

but permit covered persons to obtain medically necessary covered services from non-participating providers and still obtain some level of benefits.

Under these types of policies, often carriers will not consider a covered person eligible for in-network benefits when the covered person is admitted to a participating health care facility by a non-participating health care practitioner. The Act essentially prohibits carriers from basing the status of the health care facility solely on the status of the health care practitioner in determining whether a covered person is eligible for in-network or out-of-network benefits for the expenses related to the health care facility's services.

However, the Act does permit the carrier to still discriminate a covered person's eligibility for in-network or out-of-network benefits based on whether the covered person complied with any expressed preauthorization requirements. That is, if admission to the health care facility had to be preauthorized, this requirement is set forth in the covered person's health benefits plan, and the covered person did not seek preauthorization, then the carrier may consider the covered person to be eligible for out-of-network benefits only. (If the covered person was using a participating health care practitioner, very often some or all of the obligation to meet preauthorization requirements will rest with the participating health care practitioner.)

Proposed N.J.A.C. 8:38C-4 interprets and implements the concepts set forth in the Act. Among other things, the proposed rules clarify that they apply to situations involving any health care facility at which a covered person is admitted or treated as a patient, including clinical laboratories. In addition, the proposed rules make a distinction between those scenarios in which the obligation to meet preauthorization requirements

is explicitly that of the covered person, and those scenarios in which the participating health care facility may have an obligation under contract to meet some or all of the relevant preauthorization requirements. The proposed rules specify that when the obligation rests with the covered person, and the covered person does not meet that obligation, the carrier may determine the covered person eligible for out-of-network benefits, and provide reimbursement accordingly. When the preauthorization requirement rests with the participating health care facility, and the obligation is not met, the carrier must treat the covered person as eligible for in-network benefits; however, the carrier may impose penalties upon the participating health care facility if the contractual arrangement between the carrier and the participating health care facility provide for such penalties when preauthorization is not obtained.

The rules also acknowledge that some contracts may specify a reduction in benefits if preauthorization requirements are not met. The rules allow a carrier to reduce the in-network benefits payable for services obtained through a participating healthcare facility, rather than consider the person eligible for out-of-network benefits. The carrier would not be permitted to consider the person eligible for out-of-network benefits reduced as a penalty for failing to seek preauthorization.

Proposed N.J.A.C. 8:38C-4.1 sets forth the scope, applicability and purpose of the rules.

Proposed N.J.A.C. 8:38C-4.2 sets forth the definitions of certain terms when used in the subchapter. Among the terms defined are “health care facility,” “admission” and “patient.”

Proposed N.J.A.C. 8:38C-4.3 specifies that carriers may not determine whether a covered person is eligible for in-network benefits for expenses incurred at a participating health care facility based solely on the status of the health care practitioner that admitted and/or treated the covered person as a patient in the participating health care facility. However, the rule also states that carriers have no obligation to provide benefits or reimbursement for services that are not covered or which are not medically necessary.

Proposed N.J.A.C. 8:38C-4.4 specifies that carriers may take into consideration whether the covered person complied with preauthorization requirements in determining what level of benefits the covered person will be eligible to receive, if the requirements were disclosed in writing to the covered person. The rule also specifies that carriers may take into consideration whether the health care facility complied with any contractual obligations it may have had with respect to preauthorization or medical necessity reviews of health care services.

Proposed N.J.A.C. 8:38C-4.5 sets forth standards for paying benefits and compensating participating health care facilities under different scenarios, and clarifies when penalties may be imposed for failure to seek explicitly required preauthorization or reviews of medical necessity.

Proposed N.J.A.C. 8:38C-4.6 requires that explanations of benefits (EOBs) issued by carriers make it clear why in-network benefits have been reduced, or substituted by out-of-network benefits. Carriers are also required to specify in EOBs whether a covered person is responsible for payment of charges that have not been paid by the carrier.

Proposed N.J.A.C. 8:38C-4.7 states that the Department may take enforcement action against carriers that do not comply with the provisions of the subchapter.

A 60-day comment period is provided for this proposal; thus, in accordance with N.J.A.C. 1:30-3.3(a), this proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

Proposed N.J.A.C. 8:38C-4 should have a positive social impact. The proposed new rules set standards for carriers in determining whether a covered person is eligible for in-network or out-of-network benefits. This will be helpful to both health care facilities and consumers in trying to understand what benefits are available, whether assignment of benefits is appropriate or necessary, how billing should be accomplished, and the liability of the covered person. Heretofore, carriers were not consistent in their handling of situations in which an admission is made to a participating health care facility by a non-participating health care practitioner. The more uniform standard will reduce confusion for consumers and health care facilities.

Economic Impact

The economic impact of proposed N.J.A.C. 8:38C-4 is not clear. In certain respects, covered persons may benefit from the proposed rules, because they can mix their use of participating and non-participating health care providers, and remain eligible for in-network benefits with respect to use of the participating health care providers. Still, covered persons who do not comply with the preauthorization requirements, if any,

will not receive any economic benefit from the proposed new rules. This is likewise true for participating health care facilities. In addition, not all carriers automatically relegated covered persons to out-of-network eligibility for health care facility expenses based on the non-participating status of the admitting and treating health care practitioners. It may be that the economic impact is neutral for consumers overall.

For carriers, the economic impact may be somewhat adverse. Some carriers will incur increased administrative costs arising from having to make changes to their systems. They may also incur increased claims costs, though this may not be particularly dramatic, because preauthorization obligations are still a factor in the benefits equation. For some carriers, the economic impact may be entirely neutral, because the rules represent no change to their operations. There are no reporting or recordkeeping requirements being imposed. The economic impact upon a carrier, or the market as a whole, will depend upon the current business practices of the individual carriers, and the carriers collectively.

In general, the Department does not expect these proposed rules to have a significant economic impact upon the costs of insurance products or premiums for purchasers. Further, while the Department acknowledges that some parties may elect to utilize consultants or other outside resources in addressing the requirements of the proposed rules, the Department does not believe that compliance necessitates such expenditures.

Federal Standards Statement

A Federal standards analysis is not required because the Department's proposed new rules do not address any matter that is the subject of Federal regulation.

Jobs Impact

The Department does not anticipate any generation or loss of jobs as the result of the proposed new rules.

Agriculture Industry Impact

Pursuant to N.J.S.A. 4:1C-10.3, the Right to Farm Act, and N.J.S.A. 52:14B-4(a)(2) of the Administrative Procedure Act, the Department does not expect the proposed new rules to have any impact upon the agriculture industry.

Regulatory Flexibility Analysis

These proposed new rules do not impose any requirements that necessitate professional services. These proposed new rules do not impose new recordkeeping or reporting requirements. However, these proposed new rules may have an impact upon one or more carriers resident in New Jersey that employ 100 or fewer full-time employees, and which are not dominant in their industry, and thus, are "small businesses" as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

These proposed new rules may require some carriers, including those that are small businesses, to revise one or more aspects of their operational procedures to avoid automatically assigning out-of-network status to inpatient services when the inpatient

services are referred or performed by out-of-network practitioners. Some carriers may consider it appropriate to revise some of their disclosure statements to both covered persons and in-network hospitals to clarify certain responsibilities for obtaining preauthorization for certain services. Some carriers may have to revise their explanation of benefits in order to assure compliance with the requirements of the rules in terms of explaining more clearly why a service was considered out-of-network rather than in-network. Nevertheless, the Department does not anticipate much, if any capital expenditure requirements for compliance. All carriers currently have claims systems, various disclosure materials and explanation of benefits materials and procedures in place. No significant changes, upgrades or new systems, or new employees would be required for any carriers. The costs for those changes that some carriers may need to make in order to be in compliance with the requirements of the rules should be very modest.

Notwithstanding the impact that these proposed new rules may have upon carriers that may be small businesses, these proposed new rules do not provide any regulatory flexibility for purposes of compliance. The Act did not indicate that any such flexibility should be permitted. Further, the Department does not believe it is reasonable to reduce any of the requirements based on the size of the business. These proposed new rules seek to advance the interests and needs of consumers covered under managed care plans (with both in- and out-of-network benefits), and should not be compromised based on the size of a carrier providing the coverage. Accordingly, no accommodation for entities that may be small businesses has been made.

Smart Growth Impact

The proposed new rules will have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full text of the proposed new rules follows:

CHAPTER 38C

MANAGED CARE PLANS

SUBCHAPTERS 1. -3. (RESERVED)

SUBCHAPTER 4. COMPENSATION FOR HEALTH CARE FACILITIES WHEN OTHER HEALTH CARE PROVIDERS ARE NON-PARTICIPATING

8:38C-4.1 Scope, applicability and purpose

(a) This subchapter shall apply to all carriers that offer health benefits plans that are managed care plans in which the managed care plan includes benefits and/or services on both an in-network and out-of-network basis.

(b) This subchapter implements the provisions of section 2 of P. L. 2001, c. 367, codified as N.J.S.A. 26:2S-6.1.

8:38C-4.2 Definitions

For the purposes of this subchapter, the words and terms set forth below shall have the following meanings, unless the context clearly indicates otherwise.

"Admitted" or "admission" means the assignment of a bed or bassinet to a covered person within a health care facility, or treatment of the covered person at a health care facility as a patient.

“Carrier” means an insurance company authorized to transact the business of insurance in this State and doing a health insurance business in accordance with N.J.S.A. 17B:17-1 et seq., a hospital service corporation authorized to do business pursuant to N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to do business pursuant to N.J.S.A. 17:48A-1 et seq., a health service corporation authorized to do business pursuant to N.J.S.A. 17:48E-1 et seq., or a health maintenance organization authorized to do business pursuant to N.J.S.A. 26:2J-1 et seq.

“Covered person” means the natural person on whose behalf a carrier is obligated to pay benefits or provide health care services pursuant to the health benefits plan.

“Department” means the New Jersey Department of Health and Senior Services.

“Health benefits plan” means a policy or contract for the payment of benefits for hospital and medical expenses or the provision of hospital and medical services, that is delivered or issued for delivery in this State by a carrier. The term “health benefits plan” specifically includes:

1. Medicare supplement coverage and risk contracts for the provision of health care services covered by Medicare to the extent that state regulation of such contracts or policies is not otherwise preempted by Federal law; and

2. Any other policy or contract not otherwise specifically excluded by statute or this definition.

The term “health benefits plan” specifically excludes:

1. Accident only policies;

2. Credit health policies;

3. Disability income policies;

4. Long-term care policies;

5. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) coverage, or supplements thereto;

6. Hospital confinement indemnity coverage;

7. Coverage arising out of a workers’ compensation law or similar such law;

8. Automobile medical payment insurance or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq.; and

9. Coverage for medical expenses contained in a liability insurance policy.

“Health care facility” means a health care facility licensed pursuant to Title 26 of the New Jersey Statutes, clinical laboratories licensed pursuant to Title 45 of the New Jersey Statutes, and similar such providers of health care services licensed by the State in which the entity is located.

“Health care practitioner” means a natural person licensed to deliver one or more health care services pursuant to Title 45 of the New Jersey Statutes.

“Health care provider” means a health care practitioner, a health care facility, or other person licensed to deliver one or more health care services

pursuant to Title 45 or Title 26 of the New Jersey Statutes, or that is similarly licensed in the State in which the health care provider conducts business.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by agreement with participating health care providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of heath care services and financial incentives for covered persons to use the participating health care providers and procedures set forth in the plan.

"Patient" means an individual who is admitted to and/or is under the medical and nursing care and supervision of a licensed health care facility.

"Participating" means that a health care provider has a contractual arrangement with a carrier to provide to the carrier's covered persons the health care services that the health care provider is authorized to provide within the scope of the health care provider's license, or a more limited set of licensed services as may be set forth by the contract, with the expectation of receiving payment, other than deductibles, coinsurance or copayments, from the carrier. The term "participating" includes circumstances in which the health care provider and the carrier's contractual relationship is extended beyond the date of termination whether by force of law, or by the provisions of the contract.

8:38C-4.3 Status of health care facility not to be determined solely by status of patient's health care practitioners

(a) A carrier shall reimburse a participating health care facility for health care services rendered to covered persons who become patients at the participating health care facility at the rate contracted between the carrier and the participating health care facility regardless of whether the health care practitioner that referred or admitted the covered person, or that is providing other health care services to the covered person while the covered person is a patient at the participating health care facility is a participating health care practitioner.

(b) A carrier shall provide benefits or services to a covered person who becomes a patient at a participating health care facility at an in-network level with respect to the health care services rendered by the participating health care facility, regardless of whether the health care practitioner that referred or admitted the covered person, or that is providing other health care services to the covered person while the covered person is a patient at the participating health care facility, is a participating health care practitioner.

(c) Nothing in (a) or (b) above shall be construed to require a carrier to provide services or benefits to a covered person, or to reimburse a participating health care facility for health care services rendered to a covered person who is a patient at the participating health care facility when the health care services are not covered under the terms of the covered person's health benefits plan, or are otherwise not medically necessary.

8:38C-4.4 When preauthorization or medical necessity reviews may be considered in determining the status of a health care facility

(a) Except as N.J.A.C. 8:38C-4.5(a) applies, nothing in this subchapter shall prohibit a carrier from considering a covered person admitted to a participating health care facility to be eligible for the out-of-network level of benefits when:

1. The carrier required prior authorization for the admission and/or health care facility services to be considered for the in-network level of benefits, and these requirements have been set forth in a disclosure available to the covered person;

2. The covered person did not seek prior authorization for the admission and/or health care facility services; and

3. The participating health care facility had no contractual obligation to seek prior authorization of the admission, and/or the health care services rendered by the health care facility.

(b) Nothing in this subchapter shall prohibit a carrier from considering the health care services provided to a covered person who is a patient at a participating health care facility to be health care services to which the contracted rate of compensation does not apply when:

1. The participating health care facility had a contractual obligation to seek prior authorization for the admission and/or other health care services rendered;

2. The health care facility did not seek prior authorization of the admission and/or health care services rendered; and

3. The covered person did not have a contractual obligation to seek prior authorization for the admission and/or other health care services rendered.

8:38C-4.5 Reduction in benefits or contracted rates of compensation when preauthorization or medical necessity review was required but not sought

(a) In the event that a carrier reduces benefits for failure of a covered person to seek prior authorization and/or a medical necessity review of a health care service, and the penalty has been set forth in a disclosure available to the covered person, the carrier may apply the reduction against the covered person's in-network benefits for services obtained at a participating health care facility (for which prior authorization and/or a medical necessity review was required but not sought), rather than considering the covered person eligible for out-of-network benefits.

(b) When a participating health care facility had a contractual obligation to assure that prior authorization had been sought before admitting and/or providing health care services to the covered person as a patient, and did not do so, the carrier shall provide benefits for the covered person on an in-network basis with respect to covered, medically necessary health care services received from the participating health care facility while the covered person was a patient, but nothing in this subchapter shall be construed to prohibit the carrier from applying any penalties against the health care facility that are set forth in the

contract between the carrier and the participating health care facility for failure to seek prior authorization for covered, medically necessary services.

8:38C-4.6 Explanations of benefits

(a) Explanations of benefits shall specify clearly the reason why out-of-network benefits have been substituted for in-network benefits, or in-network benefits have been reduced, along with the percentage or amount of the reduction.

(b) Explanations of benefits shall specify whether a covered person is responsible for any of the costs charged by the health care facility for the services rendered.

8:38C-4.7 Penalties

The Department may assess fines and other available penalties under law against carriers that fail to comply with the provisions of this subchapter.